

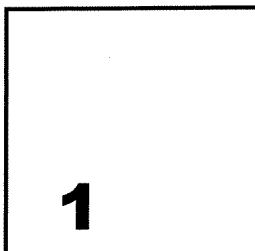
August 18, 2005

**Certificate of Need Study—  
Phase I**  
State of Washington  
*Final*

**MERCER**  
Human Resource Consulting

## Contents

1. Introduction.....	1
▪ Background.....	1
▪ Approach.....	1
▪ Purpose of CON Regulation .....	2
2. Findings.....	3
▪ CON Processes: Current Assessments.....	3
▪ Legislative Activity.....	4
▪ Affects of Repealing CON Regulations.....	4
▪ Impact of CON.....	4
▪ Cost .....	5
▪ Quality.....	5
▪ Technology .....	6
▪ Access .....	7
3. Conclusions and Suggestions.....	8
▪ Conclusions.....	8
▪ Suggestions for Phase II of the State of Washington CON Project.....	9
4. Appendices.....	
▪ Appendix A: State Standard & Review Thresholds 2005 .....	
▪ Appendix B: State Review Thresholds .....	
▪ Appendix C: CON Regulated Services.....	
▪ Appendix D: Legislative Activity — 2004.....	
▪ Appendix D: Legislative Activity — 2002.....	
▪ Appendix D: Legislative Activity — 2001 .....	
▪ Appendix E: Comments on the Effects of Repeal .....	
▪ Appendix F: Impact of CON Repeal on Growth in Acute Care Facilities .....	
▪ Appendix G: State Processes as of 2001.....	
▪ Appendix H: Utilization.....	
Endnotes .....	



## **Introduction**

### **Background**

The Certificate of Need (CON) regulations were conceived in 1964 in New York State to combat an increase in health care costs that can arise from a surplus of unneeded healthcare services.<sup>1</sup> Following its enactment in New York, many states, including Washington, drafted similar legislation that required organizations to obtain a CON before embarking on any capital projects, adding beds to hospitals and nursing homes, and purchasing medical equipment. In 1974, the federal government enacted the Federal Health Planning & Resources Development Act in response to both a general concern with increasing health care inflation and unneeded, duplicative, and costly expansions occurring because of Medicare and Medicaid.<sup>2</sup> Under this statute the federal government provided federal funding to regional health planning networks in each state. Prior to the Act's repeal in 1985, all states except for Louisiana had passed CON laws. Today, 36 states continue to enforce CON legislation (see Appendices A and B).

### **Approach**

Mercer HR Consulting performed a selected literature review of over 30 reports and articles on CON programs. Mercer focused its research on post-1999 publications so as not to repeat the sources used for the 1999 State of Washington Joint Legislative Audit and Review Committee (JLARC) study and to report more current findings. Several states, including Maine, Michigan, and Maryland, have conducted similar studies and have produced extensive reports of their findings. This paper will summarize the purpose of CON, outline the findings of the CON assessments since 1999 – specifically, the impacts of cost, access, quality, and technology – and provide conclusions and suggestions for Phase II of the Washington CON project. The processes employed by other states in implementing their CON requirements and procedures are reported in this paper's appendices.

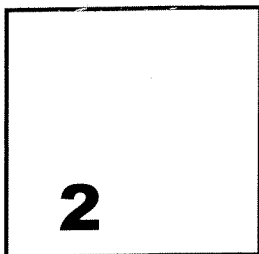
## Purpose of CON Regulation

A Certificate of Need must be issued for some health care organizations to build, upgrade, modernize, expand, relocate, or acquire any piece of equipment, facility, or service. What a CON covers varies from state to state, as do the review processes. Cost, quality, and access are factors that play into the determination of granting a CON.

CON regulation is based upon “Roemer’s Law,” which states that “a built bed is a filled bed is a billed bed” or “if you build it, they will come.”<sup>3</sup> Available hospital beds generate their own demand, and in an attempt to compete, hospitals invest in new technologies and services which create excess capacity. This hypothesis assumes that the traditional supply and demand theory in economics does not apply to the healthcare industry,<sup>4</sup> largely due to third party coverage scenarios in which consumers never realize the actual cost of the medical services they receive. Therefore, medical facilities continue building, knowing that insurance will cover the costs.<sup>5</sup> Excess capacity generated by competing facilities then leads to excess costs to combat relatively low demand.<sup>6</sup> Competition thus increases costs – as opposed to traditional economic theory in which it decreases costs.

Along with controlling costs, CON regulation has also been implemented to increase quality and access, as well as promote indigent care. Ideally, quality would be ensured because fewer facilities would be performing complex services, leading to higher volume and more experienced facilities and physicians, or centers of excellence. Access would also increase because “boutique” health care centers would be prevented from “cherry picking” highly profitable specialty services from medical care facilities, allowing the facilities to continue to profit from those specialty functions to offset certain bad debt and charity care expenses.<sup>7</sup> Ideally, this would lead to more money being invested in subsidizing indigent care as opposed to building excess capacity.<sup>8</sup>

Opponents to CON regulations contend that rather than reducing costs and increasing quality CON laws have little effect on costs and bar new entry into the market. They argue that CON laws allow existing hospitals to achieve a monopoly of services.<sup>9</sup> Supporting this argument, the findings of the Santerre and Pepper empirical study conclude that CON does deter the entry of smaller hospitals into the arena of health care services.<sup>10</sup>



## Findings

### CON Processes: Current Assessments

In many states it appears that lawmakers approve nearly every submitted application. In 2002, the Illinois CON board approved 92% of the 53 applications it reviewed. Connecticut, considered to have a more stringent CON program, approved almost all 40 projects in fiscal 2002, accepting 99% of the total dollar amount requested, at a total of \$291 million. New York, which created the CON program, approved all 170 projects submitted in 2001-2002. An extensive study of the CON program in Maine found that in the past seven years only four projects have been rejected, while 68 applications have been accepted. Finding that the current process was ineffective, Maine has placed a one year moratorium on CON approvals and has established a Capital Investment Fund to limit expenditures.<sup>11</sup>

Dollar thresholds that trigger the necessity for a CON vary per state. Of the states that require a CON for capital expenditures, 19 states set the bar at \$2 million dollars or more. Of the 25 states that require a CON for new equipment, 16 of them require a CON for expenditures over \$1 million. New services appear to be the most highly regulated component of CON laws; thresholds range from requiring approval for all services (12 states, including Washington) to any service above \$1 million. See Appendix B for further information.

State CON regulations vary in the types of facilities, services, and equipment covered. Among the regulated services are: Long Term Care, Open Heart Services, Cardiac Catheterization Labs, Rehabilitation Centers, Acute Care, Ambulatory Surgical Centers and Psychiatric Services, all of which are regulated in Washington (see Appendix C).<sup>12</sup>

## **Legislative Activity**

Despite the longevity of CON regulations, states continue to revise, repeal, and reinstate CON laws. In 2002, 20 states considered legislation affecting their CON regulations.<sup>13</sup> Most of these changes were aimed at loosening the CON requirements. In 2002, Missouri, Georgia, West Virginia, Arkansas, and Oklahoma all passed laws reducing the covered medical services.<sup>14</sup> In 2004, ten states refined their CON regulations, addressing psychiatric treatment centers, kidney disease treatment centers, critical access facilities, long-term care facilities, and specialty hospitals (see Appendix D).<sup>15</sup>

## **Affects of Repealing CON Regulations**

Fourteen states have repealed their CON regulations: Arizona, California, Colorado, Idaho, Indiana, Kansas, Minnesota, New Mexico, North Dakota, Pennsylvania, South Dakota, Texas, Utah, and Wyoming. Wisconsin originally eliminated its program but reinstated the long-term care portion. Ohio also repealed most of its CON program but retained CON requirements for long term care.<sup>16</sup> The Health Policy Tracking Service<sup>17</sup> researched these states' experiences after the closure of their CON programs. For the most part the states experienced a surge in nursing home and psychiatric bed construction (see Appendix E). Ohio in particular has seen the construction of 150 additional surgery centers and 300 additional diagnostic imaging centers since the ease of their CON program in 1995.<sup>18</sup> To combat this surge, many states have placed moratoriums on new construction, but have not indicated any legislative plans to reinstate CON regulations.

## **Impact of CON**

The initial goal of CON was to reduce costs and excess supply. As the program grew in popularity, secondary goals, such as quality and access improvements, became important targets. Since 1999, a variety of studies have focused on cost reduction and quality improvement; access has not been studied as thoroughly. However, none of these studies focused on standard metrics or outcomes for comparison, largely due to the variable concerns in each state. Overall, results are mixed as to whether cost, quality, and access have been influenced by CON regulations.

Many of the reviewed assessments of CON impact were consistent with the findings of the 1999 JLARC study.<sup>19</sup> The JLARC study found that CON had not been effective in reducing costs or in controlling supply. Evidence relating CON to quality improvement was weak, except for some evidence that home health care quality was improved by preventing unqualified providers from entering the market. The JLARC study found mixed evidence concerning the relationship between CON laws and access, concluding that the impact on access varied from state to state.

One of the major concerns about current findings is the potential bias of the articles and reports. Some of the reports were written by interest groups that may have been politically motivated in their findings. Additionally, many of the reports and articles cited research based on data accumulated in the early 1990's.

## **Cost**

States originally employed CON to promote cost containment by decreasing excess supply. It is questionable, considering the apparent overwhelming approval of CON applications, that the goal of cost containment has been achieved. Through evidence gathered in interviews, the Federal Trade Commission/Department of Justice (FTC/DOJ) report found that CON programs have been ineffective in controlling hospital costs, and in fact may have even increased costs.<sup>20</sup> The FTC/DOJ report suggests that the efforts made by the CON program may have worked when there was cost-based reimbursement, but not in the current managed care environment.

The Virginia Department of Health report concurs with the FTC/DOJ report findings.<sup>21</sup> Employing economic theory, the report suggests that because hospitals are protected from competition by CON, higher prices may be charged and less optimal quantities may be produced. Using empirical research from the 1990's, the report concluded that CON does not reduce health care costs because: 1) CON is not necessarily effective in controlling supply; 2) expenditures per bed may increase when bed supply is controlled; and 3) CON does not regulate all hospital services.

In contrast to these findings, an independent study performed by DaimlerChrysler, Ford Motor Company, and General Motors found health care costs were lower in states with CON programs.<sup>22</sup> Ford Motor Company found that there was a consistent correlation between lower costs and CON across a range of services.<sup>23</sup> General Motors recognized that CON regulations may not be the sole reason for lower costs, but may be a contributory factor.<sup>24</sup>

Conover and Sloan concluded that CON generally does not reduce costs.<sup>25</sup> Their research determined that eliminating CON does not necessarily increase costs.<sup>26</sup> However, they found some evidence that stringent CON programs may be successful in controlling costs, but overall these programs do not have an important influence on cost.<sup>27</sup>

## **Quality**

Proponents of CON regulations argue that CON ensures higher quality of services by limiting the number of competing agencies and thus increasing the volume of procedures in certified facilities<sup>28</sup>. Conover and Sloan questioned whether quality improvements are actually achieved through CON, suggesting that there may be a more efficient means of achieving quality standards.<sup>29</sup> The most referenced study concerning the relationship of

quality and CON focused on the mortality rates following Coronary Artery Bypass Graft (CABG) surgery.<sup>30</sup> The study, published in The Journal of the American Medical Association (JAMA), used data from Medicare beneficiaries who underwent CABG surgery nationally from 1994–1999. The study found that the risk adjusted mortality was 22% higher in the 18 states that had no CON regulation than in the 26 states and Washington, D.C. that had continuous CON regulations. Additionally, the patient volume was 84% higher in CON regulated states. The study also found that the number of hospitals performing CABG increased faster in states that repealed CON regulations than in states that had continuous regulation. Additionally, the proportion of patients undergoing CABG in low volume hospitals was greater in states that repealed regulations. Inconsistent with the other findings, the study showed that CABG surgery use was slightly lower in states without CON. This finding may be related to low CABG rates in states where managed care drives low surgery rates, such as in California.<sup>31</sup> The study concluded that the repeal of CON regulations may promote the development of low-volume programs which may lead to adverse patient outcomes.

A second study which focused on quality outcomes for cardiac surgeries concurred with the findings that CABG and percutaneous transluminal coronary angioplasty (PTCA) procedure volume declined in states which repealed cardiac CON legislation.<sup>32</sup> In contrast, the study found a relatively insignificant difference in mortality rates occurring in states with or without CON regulation. The study concluded that the “centralization of care which is associated with CON may lead to slightly lower mortality rates for CABG and lower unit costs due to economies of scale.”<sup>33</sup>

Some states have adopted post-CON reviews to ensure that the patients are receiving a high quality of care. In 2001, Maine adopted new CON legislation, requiring that recipients of a CON report the “impact of the service on the health status, quality of care and health outcomes of the population served.”<sup>34</sup> This report must be received in 12-month intervals following the beginning of the approved service.

## **Technology**

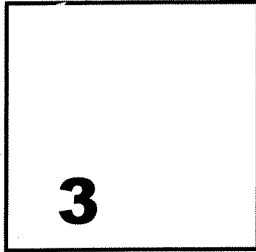
Opponents of CON regulation argue that lack of competition may hinder diffusion in technology.<sup>35</sup> The FTC/DOJ report found evidence that in one state, CON limited the application of new technologies because it denied one practice’s application to introduce new cancer radiation technology identical to the technology utilized in a neighboring state.<sup>36</sup> Conover and Sloan’s empirical study found that lifting CON did not lead to a “technology arms race” in the hospital sector. However, stringent CON programs may constrain technology growth.<sup>37</sup>

## Access

There has been little research focusing on the correlation between access and CON. Conover and Sloan report that improvements to access may be the strongest justification to continue CON regulations.<sup>38</sup> Access improvements occur for both the uninsured and for inner city and rural populations. CON laws prevent for-profit clinics from attracting privately insured patients away from hospitals, ensuring that the hospitals will not be left performing less profitable procedures and a disproportional mix of uninsured patients.<sup>39</sup> Additionally, CON has prevented hospitals from fleeing the cities to suburban areas. Interviewees in Michigan indicated that CON regulations also improved access in rural areas.

In Virginia, opponents claim that CON is used as tool to reduce competition by providing an incentive to providers that offer indigent care, when preventing duplication of services was intended to be the primary focus of CON.<sup>40</sup> The FTC/DOJ report admits that CON does play a role in ensuring access to indigent populations, however it suggests that there may be other methods of providing these services without CON.<sup>41</sup>

States have promoted providing indigent care as a major feature of granting CON. In Michigan, in order to receive a CON for any type of service or facility, the applicant must participate in Medicaid and not discriminate based on the ability to pay.<sup>42</sup> Florida has also recently enacted a similar law, requiring hospitals that offer open heart surgery and interventional cardiology to demonstrate a plan to provide services to Medicaid and charity patients.<sup>43</sup> However, the Georgia legislature, which recently revamped its CON laws (2005), withdrew the proposed requirement that a health care facility provide indigent care equal to 3% of its adjusted gross revenues in order to receive a CON.<sup>44</sup>



## Conclusions and Suggestions

Current assessments of CON's success are inconclusive. Since 1999, several states (Maryland, Michigan, Florida, Maine, and Georgia) have performed in depth research studies and have revamped their program in response to their specific findings. However, due to outdated data and potentially biased or politically charged reports, conclusive results on cost, quality, and access are not available. Additionally, analysis of CON impact may vary widely per state due to different degrees of state regulation in the specific areas of concern.

### Conclusions

From the current selected research that was conducted, the following conclusions can be made:

- the majority of states in the United States continue to administer some sort of CON program;
- every state CON program varies depending on the population, industries, statutory requirements and state policies;
- in many states that administer a CON program all applications are approved;
- most states with a CON program have some form of monetary threshold that triggers the necessity for a CON review;
- overall, those states that have undertaken legislative activity to alter their CON programs have done so by loosening requirements;
- most of the states that have repealed their CON program have created targeted moratoriums to manage increases in long term care beds;
- changes to state CON programs do not seem to follow a best practices pattern, but rather a "best fit" for the state as to policy and general health care needs;
- several states that made significant changes to their CON programs requested periodic follow up reports on quality and access improvements;

- results are inconclusive as to whether CON regulations have affected cost, quality, technology, and access, and most of the reviewed assessments agreed that ongoing research and monitoring are needed;
- several states that made significant changes to their CON programs requested periodic follow up reports on quality and access improvements; and
- a correlation exists between volume and quality; therefore, CON may be contributing to quality for procedures where volume is a significant factor.

## Suggestions for Phase II of the State of Washington CON Project

In addition to those directives required by legislation, the following are suggestions for conducting the next portion of the CON project. These are not recommendations, but rather topics for consideration.

- Review Washington CON approval and denial rate since 1999 by service or health care entity to establish current baselines.
- Contemplate the purpose of CON in Washington and the impact that may be seen in the face of cost versus capitated reimbursement.
- Consider the use of other forms of CON monetary triggers or strategies, such as the Capital Investment Fund used in Maine. (The Capital Investment Fund is the annual state budget cap for new construction or new acquisitions of technology in the health care industry. It limits the amount of spending that can be approved through the CON process.)
- Consider the use of a different fund and for hospitals and non-hospitals.
- Bear in mind the “best fit” applications of the CON processes for Washington.
- Examine the cost, access, indigent care, technology, and quality measures that have been included in the regulations of other states. Several of the studies acknowledged the ability of CON to assist with quality and access but suggested either mending the regulations to be more stringent<sup>45</sup> or finding other more direct methods to achieve these goals.<sup>46</sup>
- Consider adopting specific, clinical, evidence-based outcome metrics upon which to measure changes that may be made to the current CON processes.
- Evaluate the impact of CON on alternative medicine and population specific healthcare.
- Consider any opportunities to assist with purchasing strategies, related legislative initiatives, and business coalition influence.
- Assess the current process and the challenges that DOH has identified in the current process, i.e. “tie-breaking” strategies, and consider incorporating quality, technology, indigent care, etc. principles.
- Review the suggestions made by the 1999 JLARC study.
- Consider the impact of cultural disparities in quality of health care outcomes as influenced by CON processes.
- Evaluate whether health care insurance purchasing guidelines have a role in, or could enhance, CON processes.

# 4

## **Appendices**

- Appendix A: State Standard & Review Thresholds 2005
- Appendix B: State Review Thresholds
- Appendix C: CON Regulated Services
- Appendix D: Legislative Activity — 2004
- Appendix D: Legislative Activity — 2002
- Appendix D: Legislative Activity — 2001
- Appendix E: Comments on the Effects of Repeal
- Appendix F: Impact of CON Repeal on Growth in Acute Care Facilities
- Appendix G: State Processes as of 2001
- Appendix H: Utilization

## Appendix A: State Standard & Review Thresholds 2005

***See following attached document***

## 2005 Relative Scope and Review Thresholds: CON Regulated Services by State

This information is summarized from the 2005 National Directory of Health Planning, Policy and Regulatory Agencies, the fifteenth edition published by the American Health Planning Association, also see map).

[illegible]

**Disclaimer:** Rank order relates to volume of items reviewed, NOT intensity of analysis or conclusions which are based on Criteria and Standards and decisions

## Appendix B: State Review Thresholds

State	Capital	Equipment	New Service
Alabama	4,108,000	2,054,000	any
Alaska	1,000,000	1,000,000	1,000,000
Arkansas	500,000 Nursing Home	n/a	0
Connecticut	1,000,000	400,000	0
Delaware	5,000,000	5,000,000	n/a
Dist. of Columbia	2,500,000	1,500,000	600,000
Florida	None	None	any
Georgia	1,280,204	711,225	any
Hawaii	4,000,000	1,000,000	any
Illinois	6,543,050	6,293,090	any
Iowa	1,500,000	1,500,000	500,000
Kentucky	1,870,973	1,870,973	n/a
Louisiana	n/a	n/a	any Long Term Care/MR
Maine	2,400,000	1,200,000	110,000 capital
Maryland	1,550,000	n/a	any
Massachusetts	10,651,247	568,066	all
Michigan	2,500,000	any	any clinical
Mississippi	2,000,000	1,500,000	any
Missouri	6,000,000/1,000,000	4,000,000/1,000,000	1,000,000
Montana	1,500,000	n/a	150,000
Nebraska	Long Term Care	n/a	n/a
Nevada	2,000,000	n/a	n/a
New Hampshire	1,924,579	400,000	any
New Jersey	1,000,000	1,000,000	any
New York	3,000,000	3,000,000	any
North Carolina	2,000,000	750,000	none - certified services
Ohio	2,000,000 renovations	n/a	n/a
Oklahoma	500,000	n/a	any with beds
Oregon	Long Term Care & New Hospital	n/a	Long Term Care/Hospital
Rhode Island	2,000,000	1,000,000	750,000
South Carolina	2,000,000	600,000	1,000,000
Tennessee	2,000,000	1,500,000	any with beds
Vermont	3,000,000 hospital/1,500,000 other	1,000,000	500,000
Virginia	5,000,000	n/a	n/a

State	Capital	Equipment	New Service
Washington	varies by service	n/a	any
West Virginia	2,000,000	2,000,000	list of 23 services
Wisconsin	1,000,000	600,000	any Long Term Care
n/a: not applicable			
Source: American Health Planning Association's National Directory for 2004			

## Appendix C: CON Regulated Services

<b>Services</b>	<b>States that Regulate</b>
<b>Acute Care</b>	<b>27</b>
Air Ambulance	10
<b>Ambulatory Surgical Centers</b>	<b>27</b>
Burn Care	12
Business Compartments	2
<b>Cardiac Catheters</b>	<b>26</b>
CT Scanners	14
Gamma Knives	19
Home Health	18
<b>ICF/MR</b>	<b>25</b>
<b>Lithotripsy</b>	<b>20</b>
<b>Long Term Care</b>	<b>37</b>
Medical Office Buildings	4
Mobile Hi Tech	17
<b>MRI Scanners</b>	<b>20</b>
<b>Neonatal Intensive Care</b>	<b>23</b>
Obstetric Services	17
<b>Open Heart Services</b>	<b>25</b>
<b>Organ Transplant</b>	<b>21</b>
<b>PET Scanners</b>	<b>23</b>
<b>Psychiatric Services</b>	<b>27</b>
<b>Radiation Therapy</b>	<b>24</b>
<b>Rehab</b>	<b>26</b>
Renal Dialysis	13
Residential Care Facilities	6
Sub acute	16
<b>Substance Abuse</b>	<b>22</b>
Swing Beds	17
Ultra Sound	5

\* Data from 2005 Relative Scope and Review Thresholds: CON  
 Regulated Services by State  
**Bold = Regulated in Washington**

## Appendix D: Legislative Activity — 2004

State	Bill	Category	Comment
Hawaii	HB 2539	Exemptions	Does not require a CON for the expansion or modification of existing facilities. However, the facility must possess a statement stating that they are not required to hold a CON.
Washington	SB 6485	Exemptions	Allows a critical access hospital to increase and redistribute the total number of licensed beds for acute and nursing home facilities without a CON.
Illinois	HB 1659	Kidney Disease Treatment Centers	Requires dialysis facilities and licensed nursing homes to report statistical information which will be used to conduct analyses on the need for proposed kidney disease treatment centers.
Oklahoma	HB 2723	Long Term Care	Amends the Long-Term Care CON Act, requiring a CON for capital investments over \$1 million, acquisition of operation of a facility, or an increase in licensed beds.
Virginia		Psychiatric Treatment Centers	Rescinds the CON requirement for intermediate care facilities for the mentally retarded that will have no more than 12 beds and are located in an area that has a need for these services.
Alaska		Psychiatric Treatment Centers	Requires Residential Psychiatric Treatment Centers to obtain a CON.
Kentucky	HB 90	Psychiatric Treatment Centers	Requires Residential Psychiatric Treatment Centers to obtain a CON.
Connecticut	HB 5531	Specialty Hospitals	Allows a transfer of ownership of a surgical facility without a request for permission provided specific conditions are met.
Florida	HB 329 SB 182	Specialty Hospitals	In an effort to increase quality outcomes and reduce lengthy litigation, the state passed laws that would prevent the licensing of specialty hospitals that limit access to elective surgery, orthopedic services, and cardiac care without providing emergency services. A license may also not be issued to a hospital that restricts services to cardiac, orthopedic, or oncology specialties.
Tennessee	HB 3449	Specialty Hospitals	Mandates that outpatient diagnostic centers obtain licenses and CONs, except for hospital based outpatient diagnostic centers.

## Appendix D: Legislative Activity — 2002

---

**In 2002, eight (8) states enacted new laws concerning their CON programs.**

---

State	Bill	Category	Comment
Tennessee	HB 2272	Equipment	Requires a CON for MRI machines.
Iowa	HB 2416	ICF/MRs	Amends CON rules for intermediate care facilities for persons with mental retardation (ICF/MRs).
Kentucky	SB 185	ICF/MRs	Includes the requirement for CON for respite beds in ICF/MRs.
Maryland	HB 321	Long Term Care	Includes the requirement for CON for continuing care retirement communities.
Tennessee	SB 2809	Long Term Care	Deregulates CON for home care organizations.
Virginia	SB 490	Long Term Care	Requires a CON for nursing home beds.
Virginia	SB 543	Long Term Care	Requires a CON for the conversion of assisted living facility beds to nursing home facility beds.
Connecticut	SB 212	Process	CON letter of intent only accepted with all required information.
Connecticut	SB 360	Process	Nursing homes must file letters of intent before terminating service or decreasing bed capacity.
Maine	SB 619	Process	Prohibits building or financing a project that requires a CON without first receiving a CON. Specifies what actions require a CON and what facilities do not apply. Establishes criteria for subsequent review of CON.
Oklahoma	HB 2604	Process	Changes time period of CON review process and authorization.
Tennessee	SB 93	Process	Creates a Health Services Development Agency which oversees the CON program. Specifies what actions require CON, penalties for non-compliance, and exemptions. Set nursing home moratorium until June 30, 2003.

---

*Source: National Conference of State Legislatures, Health Policy Tracking Service, 2002.*

---

## Appendix D: Legislative Activity — 2001

---

**In 2001, nine (9) states enacted new laws concerning their CON programs.**

---

State	Bill	Category	Comment
Florida	SB 792	Ambulatory Surgical Centers	Directs the state's CON workgroup to review and make recommendations on the regulation of ambulatory surgical centers.
Montana	SB 221	Ambulatory Surgical Centers	Limits CON requirements for ambulatory surgical care through an outpatient center for surgical services, eliminates CON requirements for certain rehabilitation facilities that qualify for Medicare certification as an ambulatory surgical center.
North Carolina	SB 714	Ambulatory Surgical Centers	Amends the definition of "ambulatory surgical facility" under CON law by requiring only one operating room. Amends the definition of "new institutional health service" by including certain operating rooms. Eliminates CON for the relocation or expansion.
Alabama	HB 7c	Exemption	Exempts a new digital hospital from CON review if the hospital replaces an existing acute care hospital; extends CON review for nursing home beds until 2005.
Florida	HB 485	Home Health	Allows home health agencies holding CONs to deliver services in contiguous counties.
Maine	SB 457	Long Term Care	Requires the Long Term Care Implementation Committee to study the relationship between CON and Medicaid reimbursement and budget neutrality.
Mississippi	SB 2333	Long Term Care	Extends CON exemption for certain continuing care retirement home facilities.
Oklahoma	HB 1420	Long Term Care	Adds CON requirements for the nursing care component of a life care community.
Tennessee	HB 545	Rehab Facilities	Requires nonresidential methadone treatment facilities to send a CON application to state legislators in the district of the facilities proposed location and enables the state health commissioner to set guidelines for the location of these facilities.

---

---

**In 2001, nine (9) states enacted new laws concerning their CON programs.**

---

State	Bill	Category	Comment
Mississippi	HB 767	Requirements	Authorizes CONs for additional adolescent psychiatric residential treatment facility beds and increases the distance that health care facilities or medical equipment may be relocated without a CON.
Virginia	SB 1385	Requirements	Allows hospitals that reduced their bed capacity to become certified as critical access hospitals to operate at their prior bed capacity without obtaining a CON.

---

*Source: National Conference of State Legislatures, Health Policy Tracking Service, 2001.*

---

## Appendix E: Comments on the Effects of Repeal

State	Repeal	Comments
Arizona	1985	Following repeal there was an increase in nursing home and psychiatric bed construction.
Colorado	1987	Following repeal there was an increase in nursing home and hospital construction. Decrease in occupancy prompted the state's Medicaid office to place a moratorium on Medicaid-certified beds in nursing homes in 1990.
Idaho	1983	Repeal had no effect.
Kansas	1985	Surge in psychiatric hospitals which CON had prevented.
Minnesota	1984	Moratoriums on nursing home and hospital beds have caused no need for restoring CON.
New Mexico	1983	CON helped dispersal to rural areas. Currently over bedding and major hospital expansion is not a concern.
North Dakota	1995	Moratorium on new nursing home beds to reduce costs. There are some problems due to the construction of new facilities and diminishing population.
South Dakota	1988	Moratorium in place regarding nursing home beds which has saved the state \$50-70 Million Medicaid dollars.
Utah	1984	Surge in psychiatric hospitals following repeal which have either closed or been bought out due to industry downsizing. Nursing home bed moratorium is in place to keep Medicaid costs down.
Wyoming	1985	Limit in place on long-term care beds.
Indiana	1986	Abundance of nursing home beds, but general consensus that the CON program should not be reinstated.

## Appendix F: Impact of CON Repeal on Growth in Acute Care Facilities

	Short-Stay Beds/1,000		Admissions/1,000	
	1983-2000	Last 5 Years	1983-2000	Last 5 Years
Average Annual Change in Supply				
CON in 2001				
Stringent	-2.5%	-2.7%	-1.0%	-0.4%
Moderate	-2.2%	-2.2%	-1.1%	0.1%
Limited	-2.3%	-1.9%	-1.0%	-0.3%
Lifted CON				
Before 10/1/86	-2.1%	-1.6%	-1.2%	0.8%
10/1/86-1989	-1.7%	-1.9%	-1.3%	0.8%
1990 or later	-1.8%	-1.4%	-1.3%	0.5%
Source: AHA data & Conover/Sloan, Evaluation of Certificate of Need In Michigan, 2003				

## Appendix G: State Processes as of 2001

***See following attached document***

*Source: Certificate of Need Project Report, Maine Department of Health Services, March 2001.*

**New Hampshire  
CON Scope of Coverage**

Services subject to CON	Cost Triggers	Incentives for Preventative Services	CON Related to Health Planning	CON Related to Quality/Regulation	CON Related to Cost Control	CON Related to Access to Care
All new health services		None	Yes	Indirectly	Yes	Yes
Ambulatory Surgery Centers	Any Purchase of equipment in excess of \$400,000		CON issues a request for new services when a need is identified by the Health Services Planning and Review Board.	The Office of Community and Public Health monitors quality (CON is within this Office)	Cost control is the main function of CON.	CON applicants must identify the population that does not have access to care due to medical indigency, low income, geographic location, or the unavailability of specialized service.
Acute Care	Any expansion of an existing Acute Care facility costing \$1,759,512 or more.					Applicants must ensure that no resident of NH shall be refused services because of race, color, creed, age, gender, sexual orientation, disability, or ability to pay.
Cardiac Catheterization	Any expansion to a nursing home, Ambulatory Surgical Unit, Specialty Hospital Project or Nursing Home costing \$1,173,008 or more					
Chemotherapy						
CT						
Lithotripters						
Long Term care						
Mobile Technology						
MRI						
Open Heart Surgery						
Psychiatry						
Radiation Therapy						
Substance Abuse						

**New Hampshire  
CON Administrative Process**

Organizational Map	Public Participation	Multiple Applications	Period of Review	Standards/Guidelines Measuring Need	Post-approval Monitoring and Enforcement
CON is located in the Office of Community and Public Health within the Department of Health and Human Services. The Health Services and Planning Review Board administer the CON program.	Affected parties and the general public are informed of formal review of an application via letters and notices in newspapers. The review board must hold a public hearing during the review period where any person can testify (and is cross-examined by the applicant). (VI-XIII of 151-C:8) A public hearing to argue the final decision of the board can be called by anyone with relevant information not previously considered by the board, changes in information used by the board to make its decision, or proof that the board failed to follow the adopted procedures.	Multiple applications are reviewed simultaneously and considered in Related to each another.	90 Calendar days with the option to extend the process 30 days at the board's discretion. No review is allowed to exceed 120 calendar days.	Standards of need are outlined for each request for applications issued by the state. Section 4 Part A of the general application outlines how the applicant should address demonstration of need. Items to be covered include: Project location within service area and service area map. Site plan Services included. Description of current health system Description of target audience. Utilization rates of services in service area by payor category.	Quality assurance plan required element of application. No indication of any follow-up by CON.

## Connecticut

## CON Scope of Coverage

Services subject to CON	Cost Triggers	Incentives for Preventative Services	CON Related to Health Planning	CON Related to Quality/Regulation	CON Related to Cost Control	CON Related to Access to Care
All new health services	Any expansion costing over \$1,000,000.	Indirectly if at all	No	No	Yes	Yes
Ambulatory Surgery		The Bureau of Community Health exists within the DPH and is responsible for promoting health behaviors and providing resources to the public.	Health planning is a function of the Bureau of Health, which is separate from the Office of Health Care Access.	The Bureau of Community Health within the DPH regulates quality through the Bureau of Regulatory Services.	CON is designed to focus on cost issues.	The Office of Health Care Access oversees data collection, health planning, the CON program, and implementation of and oversight of health care reform as enacted by the general assembly.
Acute Care	Equipment Costing over \$400,000.			It consists of:		OHCA carries out an annual statewide study.
Air Ambulance				◆ The Division of Health Systems Regulation;		Goal is to improve efficiency, lower costs, coordinate use of facilities and services, and expand availability.
Burn				◆ The Division of Community Based Regulation;		
Business Computers				◆ The Division of Environmental Health, and;		
Cardiac Catheterization				◆ A legal office		
Chemotherapy						
CT						
Gamma Knives						
Lithotripters						
Long Term care						
Medical Office Bldg						
Mobile Technology						
MRI						
Neonatal ICU						
Obstetrics						
Open Heart Surgery						
Organ Transplants						
PET						
Psychiatry						
Radiation Therapy						
Residential Care						
Facilities						
Substance Abuse						
Swing Beds						

### Connecticut CON Administrative Process

Organizational Map	Public Participation	Multiple Applications	Period of Review	Standards/Guidelines Measuring Need	Post-approval Monitoring and Enforcement
CON is located within the Office of Health Care Access. It is separate from the Department of Health.	<p>If the CON application is for transfer of ownership the board may decide to hold a public hearing during the review process.</p> <p>If the CON application is for approval of capital expenditure the board will hold a public hearing in the area to be served.</p>	During the review process, the board may hold public hearings on applications of a similar nature.	90 days with provisions for a 30-day extension granted at the Commissioners request if additional information is required.		Health care providers are required to submit a compliance assessment and data required for a budget review. The follow-up process relates to cost control only.

**Maine**  
**CON Scope of Coverage**

Services subject to CON	Cost Triggers	Incentives for Preventative Services	CON Related to Health Planning	CON Related to Quality/Regulation	CON Related to Cost Control	CON Related to Access to Care
New health services Ambulatory Surgery Acute Care Air Ambulance Burn Cardiac Catheterization Chemotherapy CT Gamma Knives ICF/MR Lithotrippers Long Term care Mobile Technology MRI Neonatal ICU Obstetrics Open Heart Surgery Organ Transplants PET Psychiatry Radiation Therapy Renal Dialysis Substance Abuse Swing Beds Ultrasound	Medical equipment that costs \$1,000,000 or more Hospitals: Any capitol expenditure of \$2,000,000 or more Nursing homes: Any capitol expenditure of \$500,000 or more	None	Indirectly	Indirectly  The department may consider whether or not the quality of any health care provided by the applicant in the past meets industry standards.	Yes  Cost control is the main function of CON.	Indirectly  The department may consider whether or not the proposed services will be accessible to all residents of the service area

## Maine CON Administrative Process

Organizational Map	Public Participation	Multiple Applications	Period of Review	Standards/Guidelines Measuring Need	Post-approval Monitoring and Enforcement
The CON program is divided between two programs. The Nursing Home division of CON is located within the Bureau of Elder Adult Services within the Department of Human services. The CON program for health care facilities other than nursing homes is located within the Bureau of Health within the Department of Health and Human Services	Public notice of review of an application is published in the Kennebec Journal and other papers circulated in the affected area. A public hearing is held if requested by persons directly affected by the review.	There are provision by which the department can obtain additional information should competing applications be filed. Provisions to allow concurrent review of competing applications.	90 days with the option for a 60 day extension. A public hearing adds 60 days to the 90-day review process.	None  Applicants are required to show a need for the proposed services/expenditures exists, but there are no guidelines for how need is to be measured	

## Massachusetts

### CON Scope of Coverage

Services subject to CON	Cost Triggers	Incentives for Preventative Services	CON Related to Health Planning	CON Related to Quality/Regulation	CON Related to Cost Control	CON Related to Access to Care
New Technology, as determined by the Department of Public Health (DPH) <sup>1</sup>	N/A	Primary/preventive health care services and community contributions are required.  A "rule of thumb" is that applicant provide 5% of the capital expenditure for new or incremental community initiatives.	Projects must be the "product of a sound health planning process", including consultation with affected state agencies such as Department of Mental Health, Department of Elder Affairs and the Department of Public Welfare.  Projects must satisfy, in whole or in part, health care requirements of proposed population.  There is no state health plan.	Projects must comply with applicable operational standards. The Division of Health Care Quality licenses health care facilities and has service- specific licensure requirements for numerous services.	Objective of CON program includes "adequate health care services are made available to every person ... at the lowest reasonable aggregate cost."  Requirements for efficiently and effectively operated services and for reasonable capital and operating costs.	Applicants are routinely required as condition of approval to provide service to patients regardless of ability to pay.  Guidelines for specific new technology or service may include access criteria.
Innovative Services, as determined by DPH <sup>2</sup>	N/A					

<sup>1</sup> New technology is medical or surgical services equipment that i) has been approved by the FDA or authorized for physician use by appropriate professional societies, and ii) has been determined by DPH not to be in general use in the state for patient care by physicians qualified to use the equipment. A list of such technology is published by DPH annually.

<sup>2</sup> Innovative service that DPH determines to be innovative for reasons of quality, access or cost, such as dialysis, neonatal intensive care, and transplant services. A list of innovative services is published by DPH annually.

**Massachusetts  
CON Administrative Process**

Organizational Map	Public Participation	Multiple Applications	Period of Review	Standards/Guidelines Measuring Need	Post-approval Monitoring and Enforcement
<p>CON program (called the Determination of Need (DoN) program) is a part of the Department of Public Health's Division of Health Care Quality, which also is responsible for health care facility licensure and certification.</p>	<p>Extensive public participation process that includes "parties of record" and general public.</p> <p>Parties of record include relevant state agencies and ten taxpayer groups.</p> <p>General public may comment in writing or at a public hearing, if one is held.</p> <p>A public hearing may be requested by parties of record or may be convened by the program director if he/she believes a public hearing will assist the staff in carrying out its duties.</p>	<p>"Comparable applications" are defined as those that i) are filed within the same filing period, or, at discretion of the program director's discretion, in different filing periods in the same filing year, and ii) are for projects for "similar or reasonably interchangeable health services for applicable services areas which are the same in whole or in significant part."</p> <p>Special procedures apply for comparable applications.</p>	<p>No specific period of review is specified.</p>	<p>DoN program operates with guidelines for specific new technologies and innovative services which specify measures of need.</p>	<p>A mandatory condition on project approvals is that authorization if for a three year period. If "substantial and continuing process" is not made during the three years, the authorization expires, but can be continued of good cause.</p> <p>Condition also requires reporting to the Program Director regarding various aspects of the project and the process for immaterial, minor and major changes to the project.</p>

**Rhode Island**  
**CON Scope of Coverage**

Services Subject to CON	Cost Triggers	Incentives for Preventative Services	CON Related to Health Planning	CON Related to Quality/Regulation	CON Related to Cost Control	CON Related to Access to Care
New health services Ambulatory Surgery Acute Care Cardiac Catheterization Chemotherapy CT Gamma Knives Long Term care Mobile Technology MRI Neonatal ICU Obstetrics Open Heart Surgery Organ Transplants PET Psychiatry Radiation Therapy Rehabilitation Services Renal Dialysis Substance Abuse Swing Beds	An Expansion costing \$2,000,000 or more Any Equipment costing \$1,000,000 or more Any new services costing \$750,000 or more	Not related to CON	NO	Yes The Division of Facilities Regulation is responsible for ensuring quality. (CON is located within this division.)	Yes The Primary function of CON is cost control.	Not directly

**Rhode Island  
CON Administrative Process**

Organizational Map	Public Participation	Multiple Applications	Period of Review	Standards/Guidelines Measuring Need	Post-approval Monitoring and Enforcement
The CON program is located within the Division of Facilities Regulation within the Department of Health.	CON is required to give written notification of receipt of an application to “affected parties” at the beginning of the review cycle. Notification is also published in a newspaper having wide circulation throughout the state. A public hearing is held at an “affected person’s request. CON also accepts written comments from the public, the manner in which these comments are to be accepted is also published in newspapers.	Competing applications are reviewed concurrently.	120 days	Yes  Applicants are required to define the population served and delineate the health needs of that population. They need to inventory the facilities currently serving the targeted population and determine the portion of need not satisfied. They also need to identify and evaluate alternative proposals to satisfy unmet needs and provide justification for the proposal submitted for review.	

**Vermont**  
**CON Scope of Coverage**

Services Subject to CON	Cost Triggers	Incentives for Preventative Services	CON Related to Health Planning	CON Related to Quality/Regulation	CON Related to Cost Control	CON Related to Access to Care
New health services Ambulatory Surgery Acute Care Air Ambulance Burn Business Computers Cardiac Catheterization Chemotherapy CT Gamma Knives Home Health Lithotripters Long Term care Mobile Technology MRI Neonatal ICU Obstetrics Open Heart Surgery Organ Transplants PET Psychiatry Radiation Therapy Renal Dialysis Substance Abuse	New Services costing \$300,000 or more. Hospitals: capital expenditures of \$1,500,000 or more Other Health Facility: Capital expenditures of \$750,000 or more. Equipment costing \$500,000 or more	Indirectly if at all. The Department of Health oversees prevention programs through the Division of Community Public Health and the Division of Health Improvement. The connection to CON is unclear.	Yes The Commissioner is required to consider the goals and recommendations of the health resource management plan or the state health plan in, whichever is applies.	Indirectly if at all	Yes Cost control is the main function of CON.	Yes Access to care is a consideration in the CON process. Generally assessed by the Department of Health

**Vermont**  
**CON Administrative Process**

Organizational Map	Public Participation	Multiple Applications	Period of Review	Standards/Guidelines Measuring Need	Post-approval Monitoring and Enforcement
CON is located within the Department of Health, which is located within the Department of Human Services.	<p>The commissioner shall provide “interested parties” the information necessary to participate in the review process.</p> <p>The public oversight commission must hold a public hearing after it has decided to argue for or against the application.</p> <p>After the Commissioner has made a final decision, any party aggrieved may appeal to the supreme court.</p>	Competing applications are reviewed concurrently.	120 days with the option for the commissioner to extend the review for 30 days with written consent from each applicant.	None	Not directly related to CON

**Maryland**  
**CON Scope of Coverage**

Services Subject to CON	Cost Triggers	Incentives for Preventative Services	CON Related to Health Planning	CON Related to Quality/Regulation	CON Related to Cost Control	CON Related to Access to Care
New health services Ambulatory Surgery Acute Care Burn Cardiac Catheterization Chemotherapy Home Health ICF/MR Lithotrippers Long Term care Neonatal ICU Obstetrics Open Heart Surgery Organ Transplants Psychiatry Radiation Therapy Substance Abuse	Any expansion costing \$1,305,000 or more	Not tied to CON	Yes CON uses the state health plan as a guide.	Yes Only during review process-no follow-up.	Yes Cost control is the main function of CON.	Yes Access to care is a consideration in the state health plan and CON approval.

**Maryland**  
**CON Administrative Process**

Organizational Map	Public Participation	Multiple Applications	Period of Review	Standards/Guidelines Measuring Need	Post-approval Monitoring and Enforcement
CON is located within the Office of Licensing and Certification within the Department of Health and Mental Hygiene.	Dependant on the level of review. When applicants have not been exempted from CON review (3 <sup>rd</sup> level). Those who qualify as interested parties have the right to request oral argument or evidentiary hearing, submit written arguments and argue before Commission, request reconsideration, and appeal the decision in circuit court.	The Commission designates a single commissioner to act as reviewer for competing applications	90 days if there is no public hearing.  150 days if there is a public hearing.	Yes	

**New York  
CON Scope of Coverage**

Services Subject to CON	Cost Triggers	Incentives for Preventative Services	CON Related to Health Planning	CON Related to Quality/Regulation	CON Related to Cost Control	CON Related to Access to Care
New health services Ambulatory Surgery  Acute Care Burn Cardiac Catheterization Chemotherapy CT Gamma Knives Home Health ICF/MR Lithotrippers Long Term care Mobile Technology MRI Neonatal ICU Open Heart Surgery Organ Transplants Psychiatry Radiation Therapy Rehabilitation Services Renal Dialysis Substance Abuse Swing Beds Ultrasound	Any capital expenditure of \$3,000,000 or more  An Equipment purchase of \$3,000,000 or more		Yes	Yes	Yes.	Yes Access to care is an important part of demonstrating need.

**New York**  
**CON Administrative Process**

Organizational Map	Public Participation	Multiple Applications	Period of Review	Standards/Guidelines Measuring Need	Post-approval Monitoring and Enforcement
The CON program is located within the Bureau of Project Management within the Division of Health Facility Planning, within the Department of Health.	<p>For transfer of ownership and establishment: The State council or the health systems agency can request a public hearing to be held during the review process. If the public council proposes to recommend against the application, it must afford the applicant the opportunity for a public hearing.</p> <p>All Applications are posted on the DHS web site and the public is invited to submit comments on the posted applications</p>		<p>2 review cycles for transfer of ownership per year.</p> <p>Applications received between January 1<sup>st</sup> and June 30<sup>th</sup> shall be reviewed and presented to the state hospital and planning council before June 30<sup>th</sup> of the following year. Application received July 1<sup>st</sup> and December 31<sup>st</sup> shall be presented before December 31<sup>st</sup> of the following year.</p>	<p>Yes</p> <p>Detailed methodology to be used to determine need is outlined in section 709.2</p>	

**New Jersey**  
**CON Scope of Coverage**

Services Subject to CON	Cost Triggers	Incentives for Preventative Services	CON Related to Health Planning	CON Related to Quality/Regulation	CON Related to Cost Control	CON Related to Access to Care
New health services  Acute Care Burn Cardiac Catheterization Chemotherapy Home Health ICF/MR Long Term Care Neonatal ICU Open Heart Surgery Organ Transplants Psychiatry Rehabilitation Residential Care Facilities	Capital expenditures of \$1,000,000 or more  Equipment purchases of \$1,000,000 or more			Yes to the extent that it is related to licensure	Yes	Not directly

**New Jersey  
CON Administrative Process**

Organizational Map	Public Participation	Multiple Applications	Period of Review	Standards/Guidelines Measuring Need	Post-approval Monitoring and Enforcement
The CON program is located within the Division of Health Care Systems Analysis within the Department of Health and Senior Services.	Different review processes for different services.  Transfer of ownership-a public hearing is held within 60 days after the date an application is deemed complete		Different review processes for different services.  Transfer of ownership of a hospital--90 days		

**North Carolina  
CON Scope of Coverage**

Services Subject to CON	Cost Triggers	Incentives for Preventative Services	CON Related to Health Planning	CON Related to Quality/Regulation	CON Related to Cost Control	CON Related to Access to Care
New health services Ambulatory Surgery Acute Care Air Ambulance Burn Cardiac Catheterization Chemotherapy CT Gamma Knives Home Health Lithotrippers Long Term care Mobile Technology MRI Neonatal ICU Open Heart Surgery Organ Transplants PET Psychiatry Radiation Therapy Radiation Therapy Renal Dialysis Substance Abuse Swing Beds	Capital expenditures of \$2,000,000 or more Equipment purchases of \$750,000 or more	Not directly related to CON	Yes The Medical Facilities Planning Section located within the Division of Facility Services provides support to the North Carolina Health Coordinating Council which makes recommendations to the DHHS and Governor regarding unmet need in the state.	Indirectly The Licensure and Certification Section investigates complaints and conducts surveys on quality.	Yes Cost control is the main function of CON.	Indirectly if at all

**North Carolina  
CON Administrative Process**

Organizational Map	Public Participation	Multiple Applications	Period of Review	Standards/Guidelines Measuring Need	Post-approval Monitoring and Enforcement
The CON section is located within the Division of Facility Services within the Department of Health and Human Services	During the first 30 days of the review period any person may file written comments concerning proposals under review. A public hearing is not automatically part of the process. Under some circumstances a public hearing may be held in the affected service area no more than 20 days from the conclusion of the written comment period.	Competing applications are reviewed at the same time.	90-150 days	Yes	Yes  During the implementation of the proposed services the applicant must submit progress reports. These reports are reviewed to ensure that the project is carried out in accordance with the approved proposal.

## Washington

## CON Scope of Coverage

Services Subject to CON	Cost Triggers	Incentives for Preventative Services	CON Related to Health Planning	CON Related to Quality/Regulation	CON Related to Cost Control	CON Related to Access to Care
New health services Ambulatory Surgery Acute Care Burn Home Health Long Term care Neonatal ICU Obstetrics Open Heart Surgery Organ Transplants Psychiatry Radiation Therapy Rehabilitation Services Renal Dialysis Subacute Care Swing Beds	Capital expenditures of \$1,202,000 or more.	Not related to CON	Yes Decisions are required to be consistent with the current state health plan	Yes, but only during the implementation of the project.  The department is required to monitor the approved projects to ensure conformance with the issued CON. The department may require the applicant to submit progress reports.  There are no guidelines for follow-up after the project is complete.	Yes  Cost control is the main function of CON	Indirectly if at all

**Washington**  
**CON Administrative Process**

Organizational Map	Public Participation	Multiple Applications	Period of Review	Standards/Guidelines Measuring Need	Post-approval Monitoring and Enforcement
CON is located within the Division of Facilities and Services Licensing within the Department of Health Systems Quality Assurance within the Department of Health.	Any affected health care organization or facility can submit written comments during the review process providing that the organization requested to be informed of the department's decision.  If requested by an affected person, the department will conduct a public hearing.	Competing applications are reviewed concurrently.	90 days with provisions for two 30 day extensions if requested by the department.	The state health plan serves as a guide in determining need.	The department is required to monitor the approved projects to ensure conformance with the issued CON. The department may require the applicant to submit progress reports.  There are no guidelines for follow-up after the project is complete.

## Appendix H: Utilization

### ***See following attached documents***

*Sources: Florida CON Annual Report, 2002; Certificate of Need Phase II Study Report, Maryland Health Care Commission, January 2002.*

# HOSPITALS

## Hospital Beds and Utilization

TABLE S.1 - SUMMARY CHARACTERISTICS OF HOSPITAL SUPPLY AND UTILIZATION FROM 1992 THROUGH 2001

Year	TOTAL Chapter 395 Hospitals	GENERAL CARE HOSPITALS										SPECIALTY HOSPITALS							
		ALL Gen- eral Care Hosp.	Acute Care	NICU		Psychiatric		Substance Abuse		Rehabil- itation	SNU	ALL Specialty Hosp.	Mental Health Hosp.	Psychiatric		Substance Abuse		Rehabil- itation Hosp.	Long Term Care Hosp.
				Level II	Level III	Adult	Child Adol	Adult	Child Adol					Adult	Child Adol	Adult	Child Adol		
NUMBER OF HOSPITALS																			
1992	309	230	230	45	20	62	23	27	1	25	22	79	62	41	43	29	9	12	5
1993	307	229	229	46	21	62	23	27	1	27	29	78	60	41	41	29	9	12	6
1994	304	228	228	47	22	64	22	25	1	28	38	76	56	39	40	25	6	13	7
1995	293	223	223	50	23	64	21	26	0	28	52	70	50	38	36	22	2	13	7
1996	286	219	219	52	23	61	21	23	0	29	71	67	47	36	33	22	1	13	7
1997	278	216	216	53	24	63	20	20	0	30	84	62	40	32	24	20	1	14	8
1998	277	215	215	53	24	62	19	19	0	30	91	62	40	30	23	19	1	14	8
1999	267	212	212	55	24	63	21	19	0	30	87	55	33	26	18	15	1	14	8
2000	262	211	211	55	25	63	21	19	0	30	82	51	29	21	14	12	1	14	8
2001	259	209	209	56	25	63	20	19	0	30	64	50	28	20	14	11	1	14	8
NUMBER OF LICENSED BEDS																			
1992	61183	55482	49550	642	389	2344	459	628	10	851	609	5701	4557	1853	1831	673	200	745	399
1993	61376	55608	49409	679	421	2344	459	628	10	921	737	5768	4437	1863	1701	673	200	808	523
1994	61153	55655	49215	708	441	2328	489	589	10	945	930	5498	4062	1820	1621	521	100	853	583
1995	60208	55067	48212	731	455	2446	467	574	0	945	1237	5141	3685	1834	1425	406	20	873	583
1996	59117	54288	47197	752	455	2407	467	491	0	973	1546	4829	3373	1780	1172	406	15	873	583
1997	58127	53681	46275	771	457	2453	463	396	0	1046	1820	4446	2853	1542	936	360	15	950	643
1998	57287	53010	45529	774	457	2425	414	387	0	1054	1970	4277	2676	1442	879	340	15	958	643
1999	56536	52718	45220	800	457	2443	434	367	0	1064	1933	3818	2207	1256	681	255	15	968	643
2000	55963	52558	45119	816	463	2443	428	358	0	1064	1867	3405	1759	1018	542	184	15	1003	643
2001	55869	52463	45347	827	463	2455	398	358	0	1082	1533	3406	1745	998	556	176	15	1018	643
AVERAGE DAILY CENSUS																			
1992	32328	29393	25762	475	315	1491	227	189	*	579	355	2935	2192	1145	745	287	15	612	131
1993	31374	28475	24885	447	315	1459	181	133	*	607	447	2899	2075	1191	586	278	20	628	197
1994	30462	27526	23881	442	336	1362	164	103	*	662	578	2936	1997	1193	573	225	6	649	290
1995	29779	26933	23174	468	320	1324	152	88	0	673	733	2847	1736	1049	507	177	3	723	388
1996	29225	26535	22458	496	321	1392	151	73	0	679	965	2689	1525	944	428	153	1	745	419
1997	29997	27443	23168	519	323	1370	142	56	0	661	1204	2554	1321	812	368	141	1	789	444
1998	30190	27698	23239	541	334	1380	144	47	0	681	1331	2492	1201	700	382	118	1	818	473
1999	30628	28179	23731	553	320	1389	163	61	0	697	1265	2449	1151	616	422	113	*	810	487
2000	31109	28805	24354	533	377	1435	167	74	0	714	1153	2304	980	508	389	83	*	831	492
2001	32505	30129	25753	560	381	1499	164	75	0	714	981	2377	1014	532	414	68	*	874	488
OCCUPANCY PERCENT																			
1992	52.8	53.0	51.8	76.8	87.3	64.3	50.3	30.1	0.6	71.8	64.8	51.1	47.4	62.0	39.0	43.4	7.5	84.1	32.7
1993	51.3	51.4	50.4	67.8	79.5	62.2	39.9	21.4	0.8	67.7	67.0	49.9	46.1	64.4	33.0	41.3	10.0	80.3	37.6
1994	49.8	49.5	48.5	64.0	77.5	57.9	33.4	17.3	0.1	71.3	68.4	53.0	48.3	66.0	35.0	40.1	4.8	79.3	49.8
1995	49.2	48.7	47.6	64.5	71.6	55.3	31.2	15.0	--	71.2	70.0	53.9	45.2	57.9	32.3	42.1	7.2	83.6	66.6
1996	49.2	48.8	47.3	66.6	70.5	57.7	31.7	13.7	--	70.6	69.5	54.1	43.4	52.6	33.1	37.6	3.6	85.3	71.9
1997	51.1	50.7	49.5	68.1	70.2	56.2	29.7	12.6	--	65.6	71.4	55.6	43.3	49.7	36.0	37.3	5.7	86.3	70.3
1998	52.4	52.0	50.7	69.9	73.1	56.6	32.8	12.0	--	64.9	70.4	57.7	44.0	46.9	43.5	34.6	4.4	86.1	73.6
1999	53.8	53.3	52.4	71.2	70.0	56.1	36.5	16.2	--	65.6	65.0	59.9	46.4	44.2	52.8	41.9	0.5	84.0	75.7
2000	55.5	54.9	54.1	66.1	81.9	58.7	38.5	19.4	--	67.1	60.6	65.3	51.3	46.4	66.1	38.9	0.7	85.4	76.6
2001	58.3	57.4	57.1	68.2	82.2	61.5	38.5	20.9	--	67.0	55.3	71.3	60.5	55.4	78.8	38.7	0.0	86.3	75.9

**Number of Hospitals:** Number of hospital campuses with licensed beds of the type indicated as of December 31 of the indicated year.

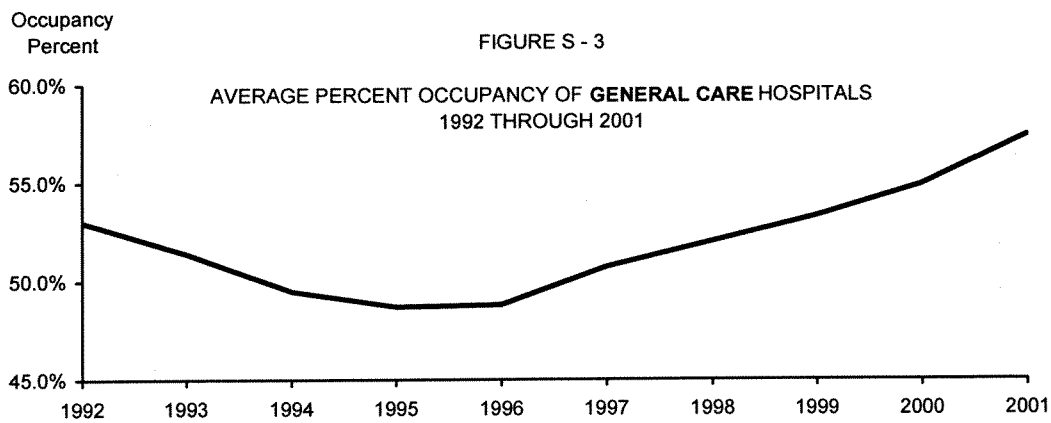
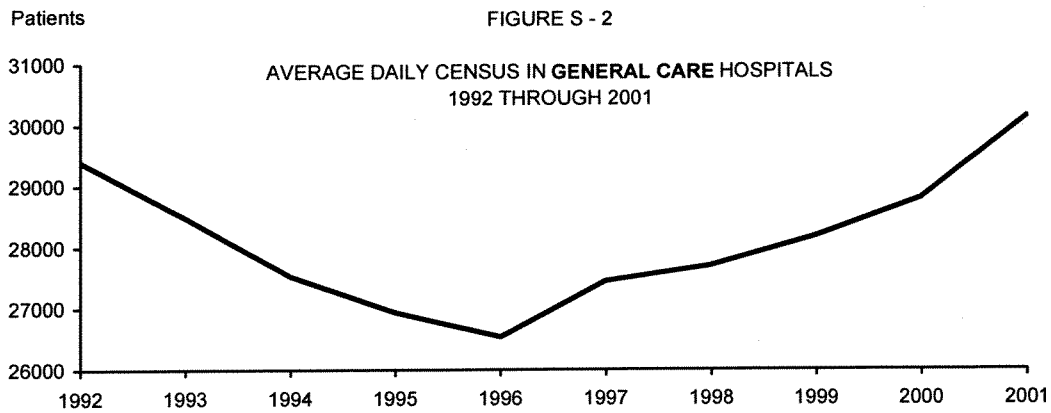
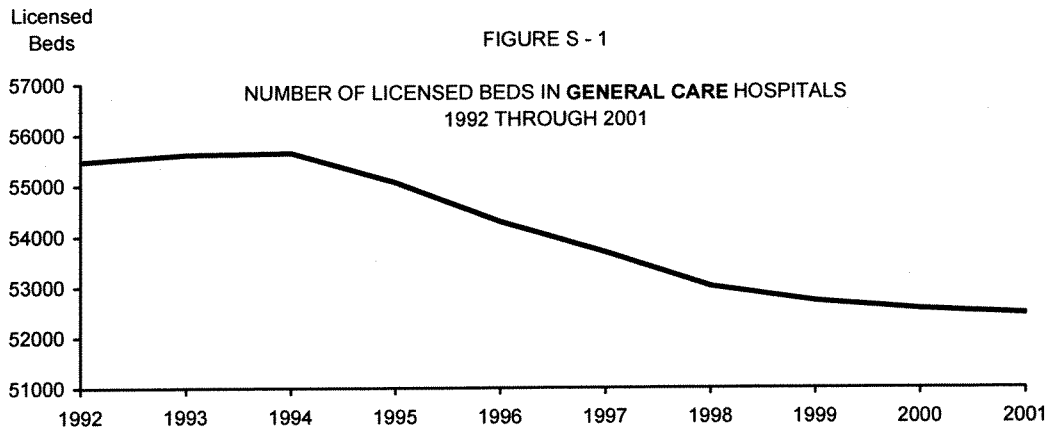
**Licensed Beds:** Licensed beds of the type indicated as of December 31 of the indicated year.

**Average Daily Census (ADC):** Yearly total of patient days divided by 365 or 366. An asterisk means the ADC was less than 0.5.

**Occupancy:** Yearly total of patient days divided by the number of bed days during that year and expressed as a percentage.

**General Care Hospital:** A hospital campus which has short-term general acute care beds and may also have specialty beds.

**Specialty Hospital:** A hospital campus with inpatient beds but no short-term general acute care beds.



Source: Inventories published by the CON Office in conjunction with bed need projections. Excludes state facilities.

Number of Licensed Beds: Number of licensed beds as of December 31 of the indicated year.

Average Daily Census: Patient days during the year divided by 365 or 366.

Occupancy Percent: Patient days during the year divided by number of bed days during that year and expressed as a percentage.

## Number of Hospitals

At the end of 1992, there were 309 hospitals licensed under Chapter 395, F.S. (excluding state facilities). At the end of 2001, there were 259 hospitals - a net reduction of 50 facilities. For general care hospitals, there was a net reduction of 21 facilities, reflecting closure of 19 hospitals and conversion of 4 hospitals to specialty facilities; this was offset by licensure of 2 new general care hospitals. For specialty hospitals, there was a net reduction of 29 facilities, reflecting closure of 35 mental health facilities, offset by 6 new facilities (1 mental health, 2 rehabilitation, and 3 long term care).

Not all services were equally affected by the changes in facilities. During this period, there were increases in the number of *general care* hospitals providing NICU services and rehabilitation services. The number with SNU services increased from 1992 through 1998, with a significant reduction since 1998. The number providing psychiatric services was essentially unchanged, while there was a notable reduction in the number of facilities providing substance abuse services. Among *specialty* hospitals, there were increases in the number of rehabilitation hospitals and hospitals with long term care beds, and a notable reduction in the number with mental health services.

## Number of Licensed Beds

The 309 hospitals at the end of 1992 had a total of 61,183 beds, while the 259 hospitals at the end of 2001 had 55,869 beds - a net reduction of 5,314 beds.

The net reduction of 5,314 beds had the following major components:

Reduced acute care beds in <i>general care</i> hospitals	(4,203)
Increased specialty beds in <i>general care</i> hospitals	1,184
Reduced mental health beds in <i>specialty</i> hospitals	(2,812)
Increased other specialty beds in <i>specialty</i> hospitals	517

## Average Daily Census

In 1992, the average daily census in Chapter 395 hospitals was 32,328 patients, including 29,393 patients in general care hospitals and 2,935 patients in specialty hospitals.

By 1996, the average daily census in *general care hospitals* had decreased from 29,393 to 26,535. Starting with 1997, however, the average daily census of patients in *general care hospitals* has been *increasing*; in 2001, the census had reached 30,129.

The average daily census in *specialty* hospitals decreased from 2,935 in 1992 to 2,377 in 2001. All of the decreases occurred in the four mental health services categories; there were increases in the number of rehabilitation and long term care hospital patients at least partly attributable to the increase in the number of hospitals providing these services.

## Average Occupancy

Average percent occupancy in *general care hospitals* has shown the same trends as the average daily census. Average percent occupancy in *specialty hospitals* has fluctuated.

**TABLE S.2 - COMBINED CENSUS FOR BED TYPES FOUND IN BOTH GENERAL CARE AND SPECIALTY HOSPITALS  
FROM 1992 THROUGH 2001**

YEAR	TOTAL Chapter 395 Hospitals	General Care Hospital	Specialty Hospital	Percent in General Care Hospitals	TOTAL Chapter 395 Hospitals	General Care Hospital	Specialty Hospital	Percent in General Care Hospitals
<b>ALL MENTAL HEALTH PATIENTS</b>					<b>REHABILITATION PATIENTS</b>			
1992	4099	1907	2192	46.5	1191	579	612	48.6
1993	3848	1774	2075	46.1	1235	607	628	49.2
1994	3625	1628	1997	44.9	1311	662	649	50.5
1995	3300	1564	1736	47.4	1396	673	723	48.2
1996	3141	1616	1525	51.4	1424	679	745	47.7
1997	2889	1568	1321	54.3	1450	661	789	45.6
1998	2773	1572	1201	56.7	1499	681	818	45.4
1999	2764	1613	1151	58.4	1508	697	810	46.2
2000	2656	1675	980	63.1	1545	714	831	46.2
2001	2753	1739	1014	63.2	1589	714	874	44.9

**DETAIL FOR MENTAL HEALTH:**

<b>ADULT PSYCHIATRIC PATIENTS</b>					<b>CHILD/ADOLESCENT PSYCHIATRIC PATIENTS</b>			
1992	2636	1491	1145	56.6	971	227	745	23.4
1993	2650	1459	1191	55.1	767	181	586	23.6
1994	2555	1362	1193	53.3	737	164	573	22.3
1995	2374	1324	1049	55.8	658	152	507	23.1
1996	2336	1392	944	59.6	579	151	428	26.1
1997	2182	1370	812	62.8	509	142	368	27.9
1998	2080	1380	700	66.3	527	144	382	27.3
1999	2005	1389	616	69.3	585	163	422	27.9
2000	1942	1435	508	73.9	556	167	389	30.0
2001	2031	1499	532	73.8	578	164	414	28.4
<b>ADULT SUBSTANCE ABUSE PATIENTS</b>					<b>CHILD/ADOL. SUBSTANCE ABUSE PATIENTS</b>			
1992	477	189	287	39.6	15	*	15	0.4
1993	412	133	278	32.3	20	*	20	0.4
1994	327	103	225	31.5	6	*	6	0.1
1995	265	88	177	33.2	3	--	3	0.0
1996	226	73	153	32.3	1	--	1	0.0
1997	197	56	141	28.4	1	--	1	0.0
1998	165	47	118	28.5	1	--	1	0.0
1999	174	61	113	35.1	*	--	*	0.0
2000	157	74	83	47.1	*	--	*	0.0
2001	143	75	68	52.4	*	--	*	0.0

Source: Inventories published by the CON Office in conjunction with bed need projections. Excludes state hospitals.

**Average Daily Census:** Patient days during the indicated year divided by 365 or 366. An asterisk indicates the average daily census was less than 0.5.

In 1992, only 46.5 percent of the total average daily census of *mental health* patients was in general care hospitals. By 2001 the total census had been reduced from 4,099 to 2,753, and the percent of that census in general care hospitals had increased to 63.2 percent. During this period, the census in general care hospitals showed comparatively little change, while the census in specialty hospitals decreased by over 1,000.

The percent of the average daily census of *rehabilitation* patients in general care hospitals was essentially unchanged from 1992 through 2001 - it was 48.6 percent in 1992; and 44.9 percent in 2001. In all years since 1994, a majority of rehabilitation patients were in specialty hospitals.

TABLE S.3 - AVERAGE DAILY HOSPITAL CENSUS BY QUARTER YEAR FROM 1992 THROUGH 2001

Three-Month Period Ending	TOTAL Chapter 395 Hospitals	GENERAL CARE HOSPITALS										SPECIALTY HOSPITALS							
		ALL General Care Hosp.	Acute Care	NICU		Psychiatric		Substance Abuse		Rehabilitation	SNU	ALL Specialty Hosp.	Mental Health Hosp.	Psychiatric		Substance Abuse		Rehabilitation Hosp.	Long Term Care Hosp.
				Level II	Level III	Adult	Child Adol	Adult	Child Adol					Adult	Child Adol	Adult	Child Adol		
Mar-92	35451	32307	28637	471	293	1523	271	198	0	581	332	3144	2380	1152	923	291	13	620	144
Jun-92	32204	29124	25519	455	323	1449	248	206	*	570	355	3079	2344	1182	849	300	13	604	131
Sep-92	30453	27670	23990	497	327	1571	193	178	0	569	344	2784	2045	1169	573	291	12	613	126
Dec-92	31235	28499	24929	477	317	1420	196	175	*	596	389	2736	2004	1078	637	267	22	611	121
Mar-93	35002	31959	28332	422	295	1502	197	159	*	631	421	3042	2190	1188	670	302	30	652	200
Jun-93	31147	28109	24558	434	312	1432	182	147	0	609	435	3038	2191	1228	669	269	25	644	203
Sep-93	29042	26248	22637	468	327	1507	162	126	*	586	435	2794	1985	1208	486	279	12	617	193
Dec-93	30382	27655	24084	464	325	1397	182	103	0	603	497	2727	1939	1139	522	264	14	598	191
Mar-94	34250	31225	27483	437	332	1439	177	108	*	700	551	3025	2138	1253	598	272	15	624	264
Jun-94	30166	27172	23551	431	329	1373	165	114	0	638	571	2994	2076	1216	630	225	5	636	282
Sep-94	28110	25257	21674	451	344	1345	143	100	0	640	560	2853	1922	1210	507	204	2	650	280
Dec-94	29401	26528	22890	449	338	1293	171	89	0	672	628	2873	1854	1095	557	198	3	685	334
Mar-95	33657	30596	26793	450	309	1333	172	96	0	745	697	3061	1933	1143	583	204	4	732	395
Jun-95	29185	26209	22556	447	287	1289	141	93	0	677	718	2975	1873	1122	562	186	2	721	381
Sep-95	27425	24697	20931	493	342	1353	134	86	0	631	725	2728	1656	1038	441	173	4	708	364
Dec-95	28929	26300	22487	481	342	1323	159	78	0	641	789	2630	1486	896	443	146	1	730	413
Mar-96	32353	29522	25496	463	302	1397	168	74	0	720	902	2831	1633	974	505	154	*	770	428
Jun-96	28797	25974	21973	475	313	1414	144	76	0	683	896	2823	1637	997	490	150	*	751	434
Sep-96	27024	24434	20289	533	340	1410	135	73	0	658	996	2590	1460	921	379	160	*	723	408
Dec-96	28753	26237	22100	513	328	1348	158	67	0	657	1065	2516	1373	883	340	148	2	737	407
Mar-97	32381	29744	25402	509	305	1422	160	64	0	705	1176	2637	1406	874	372	159	1	783	448
Jun-97	29604	27045	22755	498	322	1414	152	55	0	660	1188	2560	1326	825	361	139	1	785	448
Sep-97	28057	25514	21296	536	333	1349	127	52	0	626	1194	2543	1324	835	344	144	*	779	439
Dec-97	29994	27515	23264	533	331	1298	128	52	0	653	1258	2479	1231	713	393	124	1	807	441
Mar-98	33332	30682	26175	495	303	1380	167	50	0	724	1388	2650	1302	758	425	117	2	847	501
Jun-98	29353	26905	22449	528	312	1384	141	51	0	695	1344	2449	1152	681	344	126	1	831	465
Sep-98	28512	26068	21649	560	376	1405	124	43	0	634	1277	2444	1189	711	357	121	*	793	462
Dec-98	29622	27195	22739	578	346	1352	145	45	0	673	1318	2427	1162	651	404	106	*	801	465
Mar-99	33862	31312	26718	523	289	1421	153	71	0	750	1387	2550	1206	663	425	117	*	833	511
Jun-99	30033	27513	23055	552	313	1384	178	63	0	685	1283	2520	1207	643	435	129	*	833	480
Sep-99	28486	26115	21742	561	341	1426	147	57	0	672	1169	2371	1125	602	411	112	*	770	476
Dec-99	30195	27838	23466	575	337	1326	174	52	0	683	1226	2357	1070	557	417	96	*	806	481
Mar-00	33829	31428	26817	554	341	1451	180	73	0	747	1265	2401	1039	550	397	92	*	848	514
Jun-00	30188	27868	23430	496	363	1445	175	72	0	711	1177	2320	975	494	393	87	*	840	505
Sep-00	29509	27233	22848	549	393	1442	149	76	0	690	1085	2277	976	511	380	85	*	821	480
Dec-00	30930	28711	24337	532	410	1401	162	74	0	707	1087	2220	932	476	387	70	*	816	471
Mar-01	35104	32691	28169	517	365	1492	181	78	0	769	1121	2413	1020	525	420	75	*	898	495
Jun-01	32034	29645	25221	550	380	1491	174	75	0	724	1030	2388	1030	549	410	71	*	878	480
Sep-01	30808	28444	24070	593	391	1538	150	78	0	677	947	2363	1009	535	411	63	*	861	494
Dec-01	32128	29784	25601	581	386	1476	153	69	0	688	830	2344	998	520	414	64	*	862	485

**Average Daily Census:** Patient days during the 3-month period ending in March, June, September or December, divided by the number of calendar days in that period. An *asterisk* indicates the average daily census was less than 0.5.

FIGURE S - 4

AVERAGE DAILY CENSUS IN ACUTE CARE BEDS IN GENERAL CARE HOSPITALS  
CALENDAR QUARTERS FROM 1992 THROUGH 2001

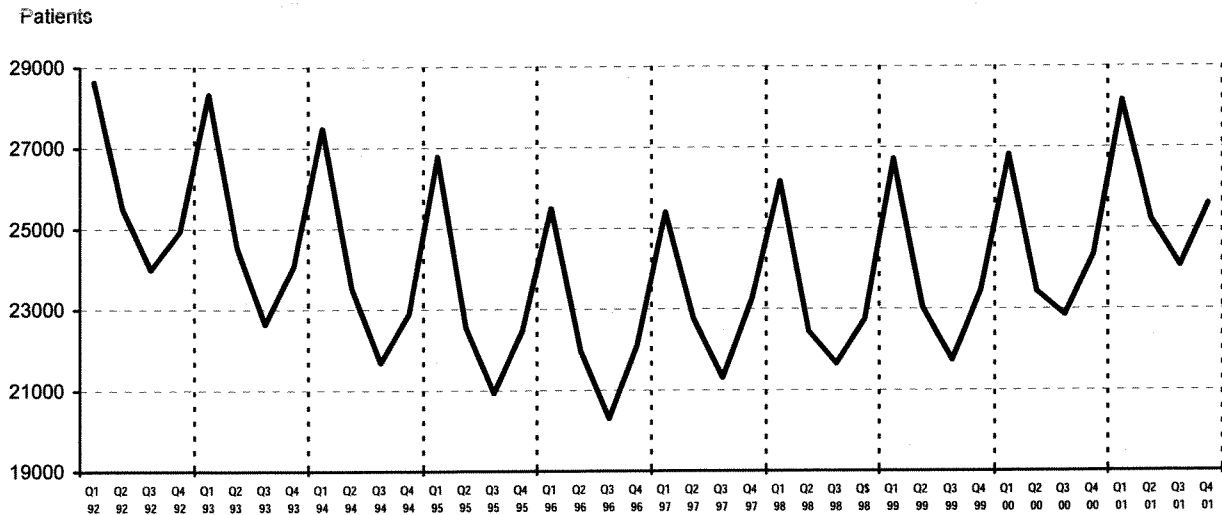
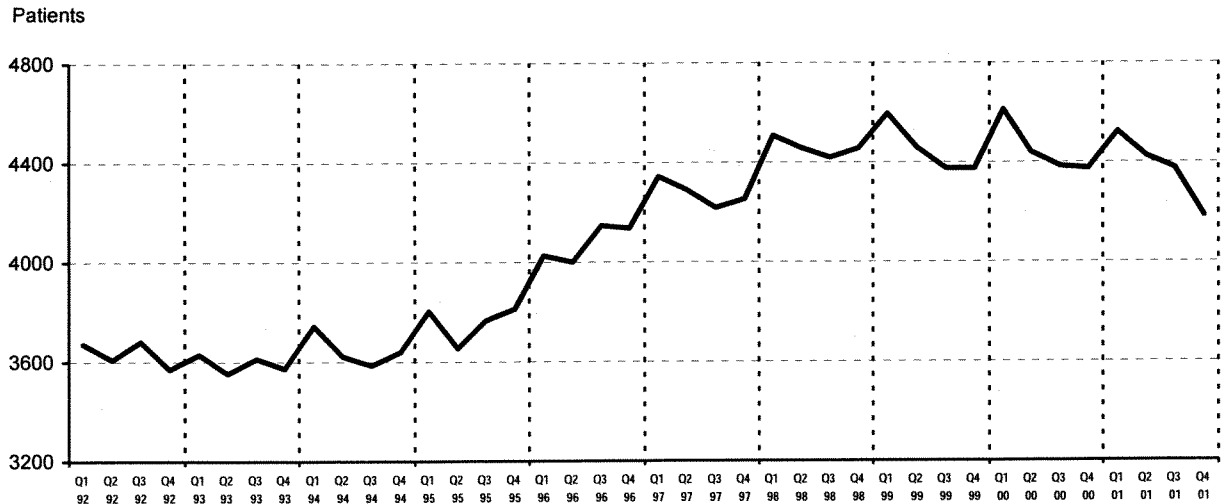


FIGURE S - 5

AVERAGE DAILY CENSUS IN SPECIALTY BEDS IN GENERAL CARE HOSPITALS  
CALENDAR QUARTERS FROM 1992 THROUGH 2001



**Average Daily Census:** Patient days during the indicated 3-month period divided by the number of calendar days during that period.

**Specialty Beds in General Care Hospitals:** NICU, Psychiatric, Substance Abuse, Rehabilitation and SNU beds.

One of the most important changes in the use of hospitals has been the movement toward shorter inpatient stays. The overall average stay for an acute care hospital patient in Maryland was 8.32 days in 1980. By 2000, the average length of stay fell by almost one-half to 4.43 days. While length

### Hospital Bed Capacity Trends

The total number of licensed acute care hospital beds peaked in 1984 and has declined steadily since that time (Refer to Table 1-1 and Figure 1-2). In 1984, the 54 operating acute care hospitals in Maryland were licensed for a total of 15,639 beds.

of stay has been declining for some time, this trend has accelerated over the past ten years. Between 1980 and 1990, hospital average length of stay fell by an average of 2.3 percent annually. More recent data (1980-1990) show hospital stays declining by 3.0 percent annually.

Following implementation of Medicare's prospective payment system in 1983, which resulted in sharp drops in hospital occupancy in Maryland and nationally, the number of licensed beds fell between 1984-1986 by 11.3 percent (1,767 beds). After remaining fairly stable throughout the 1990s, the number of beds fell sharply once again following implementation of a new

**Table 1-1**  
**Trends in Acute Care Hospital Beds and Utilization: Maryland, 1980-2000**

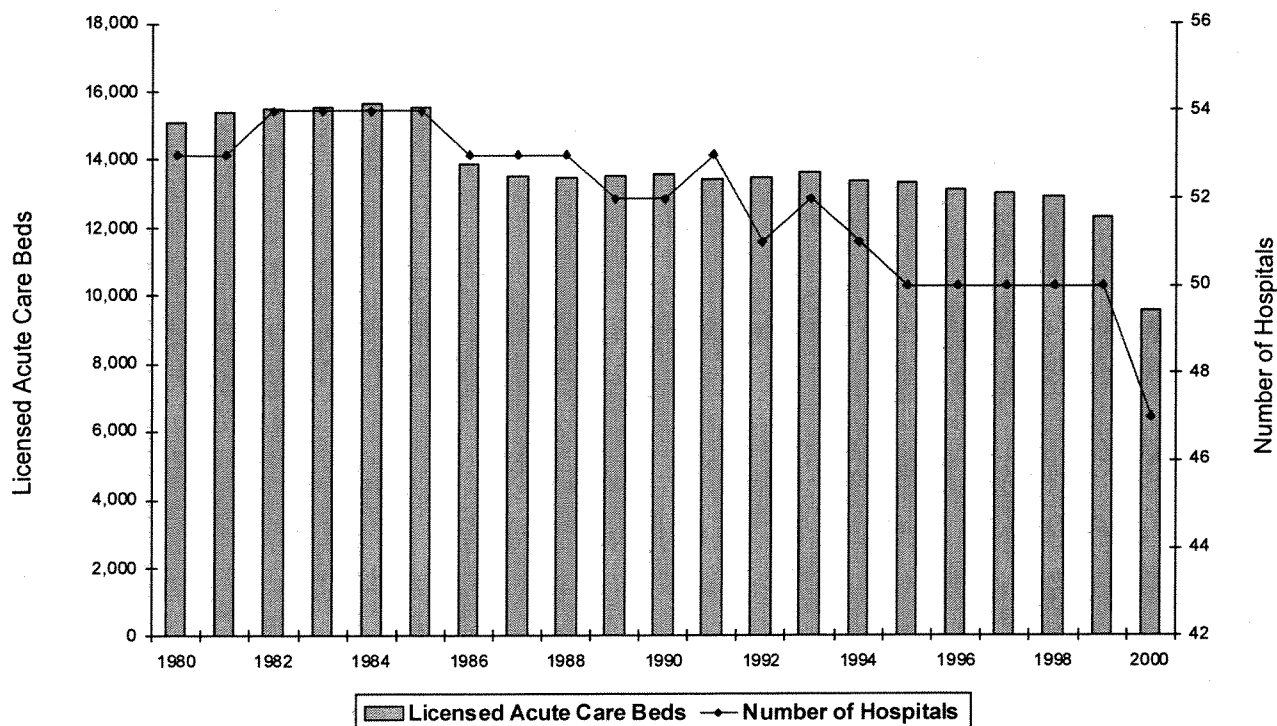
Year	Number of Acute Care Hospitals	Licensed Acute Care Beds	Total Population	Total Discharges	Total Patient Days	Average Length of Stay	Average Daily Census	Discharges Per 1,000 Population	Patient Days Per 1,000 Population
1980	53	15,082	4,216,975	527,545	4,388,984	8.32	11,992	125.10	1,040.79
1981	53	15,419	4,261,967	538,093	4,387,983	8.15	12,022	126.25	1,029.57
1982	54	15,506	4,306,959	558,001	4,419,814	7.92	12,109	129.56	1,026.20
1983	54	15,568	4,351,951	569,456	4,364,509	7.66	11,958	130.85	1,002.89
1984	54	15,639	4,396,943	569,598	4,063,725	7.13	11,103	129.54	924.22
1985	54	15,575	4,441,935	535,486	3,645,423	6.81	9,987	120.55	820.68
1986	53	13,872	4,486,927	526,583	3,602,410	6.84	9,870	117.36	802.87
1987	53	13,519	4,531,919	523,971	3,580,329	6.83	9,809	115.62	790.02
1988	53	13,505	4,576,911	535,377	3,527,158	6.59	9,637	116.97	770.64
1989	52	13,540	4,621,903	543,781	3,557,716	6.54	9,747	117.65	769.75
1990	52	13,570	4,666,897	555,081	3,547,355	6.39	9,719	118.94	760.11
1991	53	13,404	4,714,992	555,498	3,365,345	6.06	9,220	117.82	713.75
1992	51	13,439	4,763,087	556,418	3,327,500	5.98	9,092	116.82	698.60
1993	52	13,594	4,811,181	548,858	3,145,863	5.73	8,619	114.08	653.87
1994	51	13,357	4,863,201	552,480	2,940,650	5.32	8,057	113.60	604.67
1995	50	13,320	4,912,277	552,562	2,768,258	5.01	7,584	112.49	563.54
1996	50	13,136	4,947,038	547,886	2,649,938	4.84	7,240	110.75	535.66
1997	50	13,019	4,981,799	538,757	2,519,140	4.68	6,902	108.15	505.67
1998	50	12,902	5,016,560	542,261	2,481,879	4.58	6,800	108.09	494.74
1999	50	12,328	5,051,321	553,455	2,492,218	4.50	6,828	109.57	493.38
2000	47	9,562	5,086,082	568,361	2,517,965	4.43	6,880	111.75	495.07

Source: Maryland Health Care Commission (Data reported on hospital utilization is from the Hospital Discharge Abstract Data Base for calendar years 1980-2000; population data reported is based on data from the Maryland Department of Planning, Population Estimates and Projections, Revised February 2000; and data on licensed acute care beds is from MHCC inventory files.)

approach to licensing hospitals enacted during the 1999 session of the General Assembly. As of 2000, the 47 acute care

hospitals operating in Maryland were licensed for a total of 9,562 beds.

**Figure 1-2**  
**Acute Care Hospitals and Licensed Beds:**  
**Maryland, 1980-2000**



Source: Maryland Health Care Commission (Data reported on licensed acute care hospitals and beds are from Commission inventory files)

Over the past two decades, eight acute care hospitals licensed for 1,217 beds have

closed in Maryland. As shown in Table 1-2, six of the eight hospitals that have closed were located in Baltimore City.

**Table 1-2**  
**Acute Care Hospital Closures: Maryland, 1986-2001**

Hospital Closed/Jurisdiction	Date	Licensed Beds	Hospital System Affiliation
Lutheran Hospital ( <i>Baltimore City</i> )	1986	197	Liberty Medical Center
Wyman Park Hospital ( <i>Baltimore City</i> )	1986	135	Johns Hopkins Health System
North Charles Hospital ( <i>Baltimore City</i> )	1991	248	Johns Hopkins Health System
Leland Memorial Hospital ( <i>Prince George's Co.</i> )	1993	120	Adventist Healthcare
Frostburg Community Hospital ( <i>Allegany Co.</i> )	1995	37	Western Maryland Health System
Liberty Medical Center ( <i>Baltimore City</i> )	1999	282	Bon Secours Baltimore Health System
Children's Hospital ( <i>Baltimore City</i> )	1999	54	LifeBridge
Church Hospital ( <i>Baltimore City</i> )	1999	144	MedStar Health
<b>TOTAL</b>		<b>1,217</b>	

Source: Maryland Health Care Commission

HB 994, the Hospital Capacity and Cost Containment Act, has emerged as a significant factor in the future supply and distribution of inpatient beds in acute general hospitals. Under this legislation, there is an annual recalculation of hospital licensed bed capacity, which requires a yearly adjustment to the number of licensed beds each acute general hospital is permitted to maintain during the next fiscal year. The Commission works with the Office of Health Care Quality to determine the overall bed capacity each hospital will have for the next year, based on applying a factor of 140 percent of the average daily census from the last twelve months of complete occupancy data to the hospital's current bed capacity.<sup>1</sup>

<sup>1</sup> As Commission Staff described in the "fact sheet" presented to the Commission on October 25, 2000 and subsequently posted on the MHCC website, the implementation of this provision is a cooperative effort: the Health Services Cost Review Commission provides the data on which the annual calculation is based; the MHCC reviews and approves each hospital's designation of the new bed total by existing medical services and maintains a Hospital Inventory Database; and OHCQ issues the revised license total, as a letter to be attached to each

Given the next year's capacity figure, each hospital may, if it chooses, reallocate the number of beds among its existing medical services, according to previous experience or projected changes in utilization.<sup>2</sup> This provision of HB 994 took effect on July 1, 2000, and was first implemented in October of that year. The number of pediatric beds in Maryland decreased at a higher percentage (21.16%) than medical-surgical beds (7.63%) when this new licensure system was implemented.

hospital's current license, since the actual license is only issued once every three years, to coincide with the survey and re-accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

<sup>2</sup> This reallocation is permitted through an existing provision in Commission statute, originally enacted in 1988 and further clarified in regulation, that permits increases or decreases in the bed complement of an existing medical service in an acute general hospital, as long as the total bed capacity does not increase, "and the change is maintained for at least one year" unless modified by the approval of a Certificate of Need (or for a merged system, an exemption from Certificate of Need), or by a change made during the annual calculation itself. §19-120 (h)(2)(ii), COMAR 10.24.01.02A(3)(b).

## Endnotes

<sup>1</sup> *The Michigan Certificate of Need Program*, Citizens Research Council of Michigan, Report 338 February 2005, at 1.

<sup>2</sup> *Id.*

<sup>3</sup> Ellen Jane Schneider, Trish Riley, & Jill Rosenthal, *Rising Health Care Costs: State Health Cost Containment Approaches*, National Academy for State Health Policy, June 2002, at 7.

<sup>4</sup> *Improving Health Care: A dose of Competition*, Federal Trade Commission and the Department of Justice, July 2004, at 8.2-3; *See also The Michigan Certificate of Need Program*, *supra* note 1, at 5.

<sup>5</sup> Christopher J. Conover & Frank A. Sloan, *Evaluation of Certificate of Need in Michigan*, Center for Health Policy, Law and Management: Terry Sanford Institute of Public Policy (Duke University), May 2003 at 3.

<sup>6</sup> *Rising Health Care Costs: State Health Cost Containment Approaches*, *supra* note 3, at 7.

<sup>7</sup> *Improving Health Care: A dose of Competition*, *supra* note 4, at 8.3.

<sup>8</sup> *Rising Health Care Costs: State Health Cost Containment Approaches*, *supra* note 3, at 7.

<sup>9</sup> Rexford E. Santerre and Debra Pepper, *Survivorship in the US Hospital Services Industry*, 21 *Manag. Decis. Econ.* 181, 2000 at 184.

<sup>10</sup> *Id.* at 187.

<sup>11</sup> Hilary K. Schneider & Joseph P. Ditre, *When, Where and How Much: Improving Maine's Certificate of Need Program*, Consumers for Affordable Health Care Foundation, June 2004, at 8.

<sup>12</sup> Thomas Piper, *The CON Matrix of: 2005 Relative Scope and Review Thresholds: CON Regulated Services by State*, American Health Planning Association, January 19, 2005.

<sup>13</sup> Michael Romano, *Pros and Cons of Certificates: American Health Planning Association Directory Suggests that CON Process is Regulatory in Theory, not in Practice*, *Modern Healthcare*, April 21, 2003, at 4.

<sup>14</sup> *Id.* Missouri repealed its oversight on expansion of acute-care hospitals; West Virginia removed office buildings from review; Georgia eliminated several medical services; Arkansas took out sub acute care and swing beds; Oklahoma dumped requirements related to swing beds.

<sup>15</sup> Andrew McKinley, *Health Care Providers and Facilities: Certificate of Need (Year End Report – 2004)*, Health Policy Tracking Service, December 31, 2004.

<sup>16</sup> Gretchen McBeath, *Status Report on Ohio After Deregulation from Certificate of Need*, Bricker & Eckler LLP, <http://www.bricker.com/Publications/articles/533.asp>, 2001.

<sup>17</sup> *Health Care Providers and Facilities: Certificate of Need (Year End Report – 2004)*, *supra* note 15.

<sup>18</sup> Cheryl Jackson, *States Rethinking Need for Certificate-of-Need Laws As Fiscal Health of Hospitals Wanes*, AMEDNews.com, July 29, 2002, [www.ama-assn.org/amednews/2002/07/29/bisb0729.htm](http://www.ama-assn.org/amednews/2002/07/29/bisb0729.htm).

<sup>19</sup> *Effects of Certificate of Need and its Possible Repeal*, State of Washington Joint Legislative Audit and Review Committee, Report 99-1, January 8, 1999 at iii.

<sup>20</sup> Federal Trade Commission and the Department of Justice, *supra* note 4, at 8.5-6.

<sup>21</sup> *Economic Impact Analysis: Certificate of Public Need State Medical Facilities Plan*, Virginia Department of Health, August 11, 2004 at 5.

<sup>22</sup> The findings are available in Addendum J to the Christopher J. Conover & Frank A. Sloan, *Evaluation of Certificate of Need in Michigan* report.

<sup>23</sup> *Relative Cost Data vs. Certificate of Need for States in which Ford has a Major Presence*, Ford Motor Company Study, 2000 at 2.

<sup>24</sup> *Statement of General Motors Corporation on the Certificate of Need Program in Michigan*, February 12, 2002.

<sup>25</sup> Christopher J. Conover & Frank A. Sloan, *Evaluation of Certificate of Need In Michigan, Volume II: Technical Appendices*, Center for Health Policy, Law and Management Terry Sanford Institute of Public Policy, Duke University, July 2003 at 7

<sup>26</sup> *Id.* at 19.

<sup>27</sup> *Id.* at 24.

<sup>28</sup> Mark Gaffney and Martin Zimmerman, *An Old Fashion Way to Control Costs: Well Run Certificate-of-Need Programs Can Help Rein in Rising Healthcare Spending*, *Modern Healthcare*, November 11, 2002.

<sup>29</sup> *Id.* at 26.

---

<sup>30</sup> Mary S. Vaughan-Sarrazin, Edward L. Hannan, Carol J. Gormley, & Gary E. Rosenthal, *Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation*, JAMA, October 16, 2002 at 1859.

<sup>31</sup> *Id.* at 1865.

<sup>32</sup> Vivian Ho, *Does Certificate of Need Affect Cardiac Outcomes and Costs*, Rice University, October 2004 at 21.

<sup>33</sup> *Id.* at 23.

<sup>34</sup> 22 M.R.S.A. §346(3).

<sup>35</sup> Virginia Department of Health, *supra* note 21, at 5.

<sup>36</sup> Federal Trade Commission and the Department of Justice, *supra* note 4, at 8.4.

<sup>37</sup> Conover & Sloan, *Evaluation of Certificate of Need In Michigan, Volume II: Technical Appendices*, *supra* note 25, at 24 and Table 5.

<sup>38</sup> Christopher J. Conover & Frank A. Sloan, *Evaluation of Certificate of Need In Michigan*, Center for Health Policy, Law and Management Terry Sanford Institute of Public Policy, Duke University, May 2003 at 127

<sup>39</sup> *Id.* at 59.

<sup>40</sup> Virginia Department of Health, *supra* note 21, at 8.

<sup>41</sup> Federal Trade Commission and the Department of Justice, *supra* note 4, at 8.6.

<sup>42</sup> *The Michigan Certificate of Need Program*, Citizens Research Council of Michigan, *supra* note 1, at 18-31.

<sup>43</sup> Press Release, State of Florida Office of the Governor, Governor Signs Bill Aimed at Modernizing Hospital Regulation (June 28, 2004).

<sup>44</sup> Robert C. Threlkeld, *Department of Community Health Adopts New Certificate of Need Regulations*, Healthcare Update, Morris, Manning & Martin, LLP, Winter 2005 at 10.

<sup>45</sup> Christopher J. Conover & Frank A. Sloan, *Evaluation of Certificate of Need In Michigan, Volume II: Technical Appendices*, *supra* note 25, at 24.

<sup>46</sup> Federal Trade Commission and the Department of Justice, *supra* note 4, at 8.6.